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ABSTRACT

Sexism in women's health care has received increasing attention through the women's movement. Many alternative efforts at reform have been targeted to women in their reproductive years, but the older woman has not had similar efforts designed to alter her situation. A Senior Health Center was established by one community hospital to provide ambulatory services to older adults in the community. Many older women who sought the services of the Gerontological Nurse Practitioner at this center reported negative sexist experiences with health care in the past. Senior health centers can provide these patients with an alternative to the traditional medical practice. The nurse practitioner can provide the nursing qualities of caring and sensitivity to people's needs, and can add a humanistic influence on medical care. By providing accurate information to older women about their bodies and the aging process, nursing care can enhance the self-esteem of older women patients and can enable them to participate as active, informed consumers of health care. Osteoporosis, urinary incontinence, atrophic vaginitis, lifestyle adaptations to widowhood, diminished income, and relocation are but a few of the crises faced by older women and are areas in which the health provider can serve to create modes of support. (NRB)

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GENDER AND ROLE AS ISSUES IN AMBULATORY HEALTH SERVICE UTILIZATION BY OLDER WOMEN

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Ageism in health care stands as a validated fact in the literature. Sexism in health care has received increasing attention through the women's movement. Many alternative efforts at reform have been targeted to women in their reproductive years. A review of the publications on women's health issues reveals the major areas addressed to be gynecological and obstetrical issues coupled with concerns on the predominantly male physician-female patient relationship. Physicians are portrayed in the authoritative power position whereas the female patient maintains a subservient and powerless role.

Various historical, cultural and societal traditions formulate the basis for this role delineation compounded with the "good patient role" of being passive, undemanding and cooperative (traits traditionally ascribed to women). The women's health movement strives to change the sexist biases in health care by educating women to self-awareness of their rights in the health system and demystifying medicine's mystique. These efforts have been and continue to be addressed by teaching women about their bodies, sponsoring self-help groups and women's health clinics, to create an environment that empowers the female patient to join as an active participant in her own health care.

The magnitude of response stimulated by this movement is evidenced by the immense distribution of their self-help books such as Our Bodies Ourselves by the Boston Women's Health Collective (1977) and the establishment of various regional women's coalitions. For instance, in California the Coalition for the Medical Rights of Women states in their booklet that they are "a feminist organization of health activists, working together since 1974, trying to make the medical system more responsive to the needs and concerns of women." (1980)

The concerns they address are mainly reproductive and occupational. An "older" women's issue surfaced when statistics in the 70's uncovered at that time that hysterectomy was

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the most commonly performed operation in the U.S. During the 1968-77 period the number of hysterectomies increased 47%. This year Belshy (1984) noted if the current increases persist, 40% of American women will have the operation by age 50 and 50% by age 65.

The hysterectomy scrutiny arises partly from the physical danger inherent in any operation, but moreso from the psychological effects intertwined in the feminine sexuality and resultant quality of life. Notably hysterectomy and menopausal support groups are now emerging in response to the need for alternative support to existing practices.

Women's health advocates question the economic incentives that discourage preventative programs which would decrease the need for radical female organ removal. Insurance may pay for the radiation therapy to slow down a woman's cervical cancer, but not for the pap smear that would have detected it at a curable stage.

Likewise, mastectomies disfigure a feminine symbol of one's sexuality. In the past, treatment protocols for breast cancer often involved extensive radical removal of tissue done without the woman's participation in the decision-making process. Women awoke from anesthesia and clutched their chests to feel the outcome of their biopsies.

While societal pressures and medical advances have now provided the possibility of options in treatment, many older women remember vividly the results of the past treatment modalities and do not want to participate in that system.

In the community locale that I practiced in 12 miles outside of Boston, several local studies of this area uncovered 20% of the elder population had no regular source of care in an area replete with physicians. The local community hospital hired me to establish and direct a Senior Health Center to provide ambulatory services to older adults, optimally toward

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those without a regular source of care. In practice I found truth to Bloch's Women Over 40, Visions and Realities (1983) findings. She notes

> "Most of the elderly are women . . . These women have been invisible . . . in addition to suffering the prejudices of agism, older women are also subject to the prejudices sexism. Culturally the women believe they will be taken care of by the system, but the strong focus on childrearing and homemaking leave women ill prepared to cope with changing roles."

I would like to add responsibilities to the role component. Many older women came into the center upset over various bills due to limited or no experience with finances while their husbands were alive. I've taught numerous women how to write a check, balance a checkbook, and maintain records. The Medicare "This is not a bill" and approved service amounts never cease but to confuse many.

Again, Bloch continues: "Older women are socialized to the extent that they have learned to live the traditional female role of passivity and subordination. Expectations of sex role appropriate behavior in 1910 is quite different than for women today (p. 19).

Women formally helping women likewise is a relatively new concept for the older age group. My role as a GNP was the first in the community, yet I was amazed at the response to this position by women who had been avoiding contact with the health system, several over 20 years, due to negative experiences.

Reflecting back to the role expectations of 1910, I'm sure they would have been considered excentric at that time, whereas they really were expcsing today's feminist viewpoints. This subset of older women appeared to have in common a belief in themselves and their ability to care for themselves, a great deal of common sense and a vitality for life sparked with a sense of humor. They sought out my involvement to help them cope with a present health concern.

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For example:

Mrs. P, mid 80's, had no health provider for over 30 years due to her disenchantment with the traditional health care system, specifically in the treatment her mother received. She traveled from 4 communities away to meet with this GNP she had heard about through the "grapevine".

Her complaint was of a severe chest cold that she suspected, and I confirmed, as pneumonia. Her treatment necessitated hospital admission and physician management. She would only consent to this if I would co-follow her during the hospital stay. I referred her to a warm, supportive physician who was also an excellent medical manager and her medically uneventful course led to discharge in one week. My involvement constituted daily visit on rounds, interfacing with the physician to clarify the treatment regimen and answer her and her daughter's questions. It amounted to a minimal time involvement and no dramatic interventions were made.

Afterwards, I was greatly surprised to be shown a letter by the hospital administrator from Mrs. P in which she extolled the positive benefit of having a GNP involved in her care, to personalize it and respect her concerns. What she touched upon correlates with Marieshend's (1980, p. 287) observations about today's women's health activists and "their desire to effect change in the structure and substance of the health care delivery system, to focus on issues of qualitative care and the empathetic organization and delivery of health services to women."

Another older woman recounted her frustration with care this way:

> He had an excellent reputation for being the best doctor to have if anything serious happened . . .
> Yet, I left his office and cried over my questions never asked, never answered . . .
> It was clear he had little time, an office full of people waiting,
> I felt like an intruder
> I was a nobody among many others,
> Is this the sacrifice you have to go through to get the best?
> Why does it have to be this way?"

It doesn't have to be, but the system has to become aware that problems do exist in its treatment of older women. The following anecdotal experiences will try to underscore issue.

Miss D., in her mid 70's, had cataracts removed from both eyes and now needed to insert contact lens daily to see. Due to the decreased sensitivity in her fingers and minimal vision without the contact, she "lost" the lens in her eye one night while attempting to remove it at bedtime. Unable to remove it and concerned that it may damage her eye she went to an emergency center for assistance.

From the physician she received a stern lecture on being too old a woman to learn the contact lens technique, it was useless to try. He patched her eye, told her to take a cab in the morning to the eye doctor who felt someone her age could do this, and show him what happened.

The next day she came into my office demoralized and started to cry as she told of her ordeal. She felt humiliated and angry. As she talked, it was evident she needed the contacts for the better vision and less distortion than glasses. She had been an accountant and continued in the role as a volunteer for one of the senior organizations.

We agreed that I would act as a facilitator, a backup support for her lens removal. We established a mutually convenient schedule and in a 3-week period she only needed my technical assistance twice. The rest of the time it was morale building and support for her efforts. She now functions independently.

Question: Would she have incurred the derogatory, punitive treatment if she had been a 20-year-old male or female with the same dexterity problem?

Mrs. A., 68, appeared as an overweight, hypertensive noncompliant with her medications and having been through 5 physicians in 5 years. In each case she faced humiliation and

anger by the provider for her non-compliance. She was yelled at, threatened, etc. and finally told to seek another doctor. Mrs. A. tried and failed several commercial weight loss programs. She presented herself as hopeless and worthless "old" woman. Briefly, the nursing interventions focused on increasing her self-esteem and working on assertiveness training to release and articulate her needs. Her obesity involved behavioral management techniques with the belief that she could not fail, positive reinforcement exclusively prevailed. Within 2 months her weight started slowly but progressively downward. We contracted medication taking and agreed to review it after each 10-pound weight loss. She did lose her weight and controls her hypertension on minimal drug use which she is in total compliance with. Mrs. A. moved from a state of powerlessness to control which appeared to have made the difference.

Recently, I was asked to participate in a BSE teaching and screening program for older women in a community where their past efforts to this population was not received well. They noted a significant difference between the hospital based physician run session and our community based GNP program which was well attended.

Participants frequently mentioned with emphasis on the positive nature of having a nurse examine and explain the process and spend time answering their questions.

One participant pressured to have us do pap screenings. The hospital representative told her there were no plans at present, but would be glad to refer her to a staff M.D. She didn't want to see an M.D. for a formal evaluation at present, and no other recourse/alternative was identified. Speaking with her privately, I found she was having post menopausal bleeding. Concerned over her symptomatology, I reiterated the need for a followup. I mentioned the NP run Senior Center

in the neighboring town. Here she could get a pap test done quickly and be assisted to get any followup needed. By the time I returned to the center 4 hours later, the secretary informed me of her appointment. This woman otherwise would have received no health services.

What's the difference? An alternative was offerred for this woman and the others - for the first time they had a choice besides the traditional medical practice. Their behavior indicates a past withdrawal and avoidance of care in reaction to negative experiences. The present behaviors indicate a willingness to reenter the system through the services of the nurse practitioner who brings the nursing qualities of caring, sensitivity to people's needs, and adds a humanistic influence in medical care.

By providing accurate information to older women about their bodies and the aging process, nursing care decreases the powerlessness and victimization imposed by a lack of awareness. Knowledge empowers women, it enhances their self-esteem and enables them to participate as active, informed consumers of health care. Thompson (1981) notes that "Nurses often have led the health team in teaching others to care for themselves, possibly because of their educational focus on the promotion of health rather than the medical model of curing disease."

Marieshend adds:

"The goal of realizing a woman's potential is seen in terms of alleviating this sense of helplessness or powerlessness. Questioning the health care system is seen as an appropriate beginning for women to establish control over other aspects of their lives." (1980, p. 294)

"Therefore, through self-help groups and women's clinics women are encouraged to maximize the physician-patient encounter to avoid feeling intimidated, to question medications, and

Rx recommendations, and to undertake responsible participation in their health care." (1980, p. 300)

These statements written in particular for women facing reproductive issues hold true for the older women facing post-reproductive issues. The women's movement in its maturing needs to reach out and support older women's access to health services, provisions for alternative or collaborative efforts targeted to the needs of older women. Controversies in medical treatment do exist for older women's issues such as osteoporosis (fluoride and/or calcium supplementation), urinary incontinence (surgical or medical interventions), atrophic vaginitis (estrogen replacement), lifestyle adaptations to widowhood, diminished income, and relocation are but a few of the crises faced by older women and areas in which women's activism can serve to create modes of support.

Summary

Sexism in women's health care has received increasing attention through the women's movement. Many alternative efforts at reform have been targeted to women in their reproductive years. The older woman has not had similar efforts designed to alter her situation. Is this due to the lack of the need for such services, or the failure to identify older women's needs? - A feminine ageism.

This paper reports the phenomenon of a subset of older women specifically seeking Gerontological Nurse Practitioner services in response to self-perceived negative sexist experiences with medical care. Common themes of concern, particularly the health provider's sensitivity to them as women were identified.

For this population, the GNP as a caregiver, can serve the older woman as a humanistic advocate and a means to rejoin the health system.

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